

VULNERABLE POPULATION FINDINGS

INTRODUCTION

“As members of human communities, we are all potentially vulnerable”¹
LuAnn Aday

“Better-integrated and better-organized systems of care promise potentially high quality and effective care, but only if a commitment is made at the outset to strong quality assurance, a service ethic that cares for the whole person, and outreach to those in the community who are most in need”²

Joyce Dubow

Serving the special needs of vulnerable populations creates a unique challenge for managed care organizations, be they health plans or provider organizations contracting on a prepaid capitated basis. Managed care does have a great potential for better serving vulnerable beneficiaries by providing more effective management, coordinating multiple medical and social services, and exercising greater flexibility in providing the care that beneficiaries may require.³ However, the capacity of a plan to provide appropriate care for persons with chronic or complex illnesses and circumstances depends to a large extent on the way the plan is organized and financed. Appropriate staffing and coordination of services is as critical to quality of care as is adequate risk adjustment to the financial stability of plans.

Traditionally society has recognized vulnerable individuals and groups and supported public health and treatment-oriented programs and services to address their needs. The interface of managed care plans with the public health and other safety-net providers for at-risk persons is of major concern for all vulnerable groups. In this paper we make recommendations that apply to all vulnerable populations, and that are specific to populations that receive care through government’s contractual relationships with providers.

As government payors move larger portions of Medicare and Medicaid beneficiaries into managed care, the need to address safeguards for vulnerable populations has come to the collective forefront of federal and state policy makers’ agendas. At stake is the health status of beneficiaries who have come to rely on regulatory safeguards and governmental oversight to protect their general interest through contractual requirements negotiated with managed care health plans.

¹ At Risk In America: The Health and Health Care needs of Vulnerable Populations in the United States, 1993.

² Medicare Managed Care: Issues for Vulnerable populations, Public Policy Institute of the AARP.

³ Interview Dr. Helen Rodriguez-Trias, Taskforce Member and Mary Dewane, CEO CalOPTIMA.

The movement of significant beneficiary pools from fee-for-service to managed care also has an effect on the commercial health plan industry and the provider community. Commercial and public health plans participating in Medi-Cal and Medicare must make significant investments in provider network development, information systems, and clinical quality and utilization management. Medi-Cal contracts require greater access, improved quality, and enhanced choice. These demands, place at risk an entire safety-net system of care which might not be able to manage the transition cost. At greatest risk is the county health care infrastructure. Counties may be unable to compete for members who may, for the first time, be presented with recognizable choices, not just of health plans but of private and public delivery systems.

The true power of the payor to cause the managed health care industry to change has been greatly enhanced by the sheer size of the populations being moved into prepaid health plans. The impact on the behavior of both public and private health systems now thrown into direct competition for health plan membership will be significant.

Within these specially funded health care programs there are a number of special need and vulnerable populations, some of whom are highlighted in this report:

- Frail elderly
- Disabled adults
- Disabled children
- High risk pregnant women
- Foster children
- Chronically ill, HIV/AIDS
- Socially and economically disadvantaged

These populations present a unique challenge to managed care organizations and, to a great degree, will serve as the publics' litmus test as to whether managed care can and will be the principal model of health care delivery beyond the year 2000.

Findings for Vulnerable Population in Managed Settings

The results of Miller and Luft's recent study⁴ on managed care versus FFS performance indicates that HMOs produce better, the same, and worse quality of care depending on the particular organization and particular disease. In regards to the chronically ill or diseases that require the most care there were indications that these populations and illnesses fare slightly worse in managed care, although the trend was not overwhelming. However, three of the five observations with significant negative HMO results focus on chronically ill, low-income enrollees in worse health, impaired or frail social health maintenance organization (SHMO) demonstration enrollees, and Medicare home health patients, many of whom have chronic conditions and diseases. While it is true that some quality of care results that show better or mixed HMO quality are also at least partially based on data for patients with chronic conditions and diseases, and that there are many valid cautions

⁴ Does Managed Care Lead to Better Or Worse Quality of Care?, *Health Affairs*, September/October 1997.

against over-interpreting the results, the fact that three significantly negative HMO quality of care results for Medicare HMO enrollees with chronic conditions and disease warrants attention. In addition, based on the interviews with the many advocates and foundations contributing to this report, managed care seems to present the following challenges that need to be addressed in serving these populations:

- Under-treating patients with chronic illness
- Restrictions in seeking specialists
- Lack of expanded systems of care and limited benefits definition
- Discontinuity of treatment
- Lengthy time frames for authorization
- Lack of consumer understanding

Recommendations for Improving the System

Recommendation 1

The first step for improving the care of vulnerable populations in managed care systems is for the State to contract only with those health plans that are able to identify, track, and report performance outcomes for their vulnerable populations effectively. The State of California will drive the quality of care standards and processes for the managed care industry because of both governmental payor and public employee beneficiary leverage. The task force also strongly encourages other purchasers to require appropriate identification, tracking, and reporting of vulnerable populations in their contracts as well. Currently, many plans rely on independent physicians to identify and meet the special needs of their patients. There is limited effort on the part of the plans as a whole to identify these populations systematically and strategize around them to develop “best practice” treatment practices that can be shared and applied more broadly. Appropriate identification targets those populations where proactive case management will reduce the vulnerability or help maintain functional status, and allows the state to hold plans accountable for meeting enrollees’ special needs. It goes beyond eligibility, for example, to categorizing by diagnostic disease category and/or social and economic risk factors, such as illiteracy or candidacy for abuse. Identification should occur at the time of enrollment or physical assessment, at which time issues of patient confidentiality should be addressed through informed consent.

Tracking is an on-going process which ensures that the aforementioned challenges are comprehensively addressed in a systematic way. Appropriate tracking includes proactive case management and care coordination, programs linking enrollees to community agencies or programs providing wrap-around services, appropriate provider network and credentialing to ensure sensitivity, skills, and competencies in regards to these populations, and reporting on performance outcomes. In order to implement this recommendation, procedurally plans must perform the following steps:

1. Assess the general demographics of their member population

2. Segment population
3. Identify vulnerable groups
4. Strategize around groups
5. Develop standard protocols and programs and/or identify existing “best practice” protocols and programs in the community
6. Measure and report on standard performance outcomes

Not only should this recommendation control costs by improving long-term quality outcomes, but comparable quality outcome measures are not possible without segmenting the population. There are several pre-requisite requirements that the state must implement in order to enable the recommendation:

1. Implement risk adjustment per the recommendations in the task force’s report on Risk Adjustment.
2. Develop more comprehensive enrollment forms or a similar tool to be used at time of first visit to collect better demographic and health data upfront, provide this information to plans, and hold plans accountable.
3. Require reporting of standard performance measures that are important to vulnerable enrollees, and publish comparative data among plans.

In presenting this recommendation, the task force gave special consideration to the costs of implementation. In fixed-cost programs, every increase in costs translates into a decrease in services. With the exception of risk adjustment and reporting, in and of themselves, the costs should be minimal. Collecting additional information at the time of enrollment, simply means that additional data elements are added to the form. In some cases, the data actually is already being collected, and it is simply a matter of providing this information to the plans. Credentialing is currently done; what is proposed is expanding the process to include issues of physician competence and skills in regards to particular populations. For example, knowledge of the particular wrap-around services available to certain groups through community organizations. Defining standardized performance measures and collecting data is expensive in terms of the investment in time to reach consensus around measures, and the supporting technology that will be required. However, this is an imperative for the industry as a whole, not only vulnerable populations. Without comparative data consumers will be unable to make informed choices about their healthcare plans.

Recommendation 2

The task force recommends that going forward the State “ earmark” and allocate a portion of the billions of dollars on costs avoided attributable to MediCal selective contracting and CalPERS managed care to begin expansion of coverage for California’s uninsured.

In implementing this recommendation the task force views the State’s role as being one of incentivizing the counties versus establishing a new entitlement program for the state. The task force believes this to be appropriate, since the definition of vulnerable will vary by county, and a state-wide solution will not meet the individual needs of the different

Preliminary Draft—For Discussion
(Contents and Recommendations Herein Have Not Been Approved by the Task Force)

counties appropriately. In addition, county financial resources support a great deal of this care, and much has been invested in the development of the existing safety-net. It is important to draw upon these resources and identify how to utilize them in creative, new ways, rather than starting from scratch. Several Boards of Supervisors have already begun this process by developing plans for rolling their Section 17,000 uninsured into managed care, and other counties should be able to build upon the progress that has been made to-date. This recommendation is much more incremental in nature than a state-wide solution, relying on the state to energize and incubate county initiatives, and then disseminate innovate models to be expanded and built upon.

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Guiding Principles and Recommendations for Serving Vulnerable Populations in Managed Care

In addition to the two recommendations presented above, a model for effectively providing care to vulnerable populations is presented in the body of this report. Summary guidelines for this model are presented in the matrix below which address many of the specific findings referenced earlier. This matrix was prepared in collaboration with many foundations, advocates, and individuals representing vulnerable populations. The task force formally acknowledges their participation in Appendix B of this report.

<u>ACCESS</u>	<u>QUALITY</u>	<u>BENEFITS</u>	<u>PROTECTION</u>
<p>1) Purchasers encourage plans to allow specialist PCPs for members with specific illnesses (Recommendation Physician-Patient Relationship)</p> <p>2) Plans pay for appropriate care from qualified out-of-network provider if plan doesn't include specialty provider qualified to treat enrollee's condition</p> <p>3) Plans to demonstrate integration of acute and long-term care services, as well as linkages to social services in community</p> <p>4) State require and monitor plans compliance with federal and state nondiscrimination and accessibility standards as a condition for retaining their license to operate</p>	<p>1) Plans identify and track medical and social-behavioral needs of vulnerable populations (Recommendation in Vulnerable Populations Report)</p> <p>2) Plans provide services consistent with recognized clinical guidelines and community standards germane to specific medical quality and access</p> <p>3) Plans to credential/certify medical groups and providers based on their knowledge, sensitivity, skills and cultural competence to serve vulnerable populations</p> <p>4) Purchasers adjust payments for quality</p> <p>5) Plans to work with vulnerable populations to adopt or build upon existing quality methodologies (e.g., QARI guidelines) and indicators (e.g., quality of life and functional status, cultural and linguistic aspects of care, and basic health behavior education) for vulnerable populations (Recommendation Physician-Patient Relationship Report)</p>	<p>1) Purchasers to implement risk adjustment (Recommendation in Risk Adjustment Report)</p> <p>2) The Governor and the legislature to direct the State's health plan agencies to ensure that at least 3 of the 5 standard reference coverage contracts meet the expanded benefit and accelerated authorization needs of the chronically ill, and are developed with the active participation of these groups and their advocates (Recommendation in Standardization Report)</p> <p>3) Plans that choose to contract with provider networks through shared risk contracts validate that the capitation rates are appropriate to the expected level of medical risk</p> <p>4) Legislature appoint a Blue Ribbon Panel to achieve consensus on the definition of medically necessary and appropriate and incorporate the concept of maximizing functional capability, which includes maintaining function and preventing or delaying deterioration or loss of function (Recommendation in Who Practices Medicine Report)</p> <p>5) The regulatory authority to require plans and medical group/IPAs to write contractual arrangements that enable chronically ill, acutely ill, or pregnant women to continue seeing their doctors for an extended period of time, unless removed for poor quality (Recommendation Physician-Patient Relationship Report)</p>	<p>1) Plans communicate clearly to enrollees the type of HMO, coverage formularies, customer satisfaction and customized quality measures (Recommendation in Physician-Patient Relationship Report)</p> <p>2) Plans not only to provide written evidence of coverage and membership handbooks, but also enrollees' understanding of coverage member rights, and benefits</p> <p>3) Plans to allow advocates to assist vulnerable in navigating the administrative or clinical grievance processes of the plan or develop ombudsperson programs to assist the members' rights are protected</p> <p>4) Plans to establish advisory boards with representation from health care professionals, advocacy groups, and consumer representatives for vulnerable groups</p> <p>5) Plans incorporate multimedia education and other innovative techniques to ensure user friendly member education</p> <p>6) State prohibit discharge of enrollee or placement of enrollee in any institutional setting w/o informed consent</p>

VULNERABLE POPULATIONS BACKGROUND PAPER

CHARACTERISTICS OF VULNERABLE POPULATIONS

Definition

Vulnerable populations may be defined in many ways. For the purposes of this discussion, “vulnerable” will be understood to include individuals or groups who because of age, ethnicity, race, economic condition, social circumstances, geographic location, gender, belief system, culture, education, language proficiency, mental and or physical condition do not have access to adequate healthcare services. By definition then, vulnerable populations encompass the over 6.5 million Californians whose access to health care is severely limited because they have no coverage and the over 3 million Californians whose income or illness qualifies them for MediCal.

The Managed Healthcare Improvement Task Force has, for the time being, limited its discussions to the impact of managed care on individuals who are currently managed care enrollees, and on the uninsured, whose access to healthcare may be impacted by the more competitive environment. Characteristics of vulnerable populations inside the system will be defined below, and the uninsured will be included in the discussion of safety-net providers in section four of this report.

Therefore, within that narrower framework, vulnerable populations in the managed care system are those who are likely to require above average quantities and, or, mixes of services essential to maintain or improve their health status. They may be grouped into categories that make for their vulnerability, but, that are not necessarily mutually exclusive. The following factors may render a population vulnerable:

Nature of Illness or Condition

Healthcare needs are less likely to be met for persons who have complex, chronic, unpopular or rare illness. Examples abound, but HIV/AIDS, chemical dependency and mental illness deserve special attention. Likewise, persons with restricted mobility, impaired mental processes, or sensory deficits will require ancillary services not readily available in primary health care settings.

Social and Economic Circumstances

To mention but a few, individuals caught in webs of poverty, imprisoned persons, persons without homes, migrant people and recent immigrants are more likely to have poor health status associated with lack of services.

Place of Residence

People in isolated or hard to reach areas of the state, particularly those living in rural areas frequently have difficulties accessing quality services. In urban settings there are communities that lack safe transportation thus limiting access.

Age

Children are dependent on their caretakers as may be the infirm elderly for their access to care. Adolescents may find few knowledgeable providers or services that conform to their needs for confidentiality and ready availability. Unless covered for a full range of reproductive and sexual health services they may go unserved.

Gender and Gender Identity

Women specific or in some cases men specific services may be lacking. Cultural expectations and biases around gender identity and sexual preferences creates barriers to access.

Culture and Language Proficiency

These are not the same, but are grouped because the misunderstandings around them may generate the same result, poor care and a lack of trust relative to health services.

With all of the people who might be termed vulnerable, the common denominator is that they require a mix and an intensity of services that are not by and large the rule in managed care. We have used these characteristics to identify vulnerable groups (see Table I attached) and their special needs within the system. The governmental programs that offer support to these groups are also presented (see Table II attached).

Problems of Vulnerable in Managed Care

Many argue that while managed care is effective at handling healthy populations, they do not fare as well with the more vulnerable. The quality data that exists today indicate that some pattern exists for the vulnerable to fare slightly worse in a managed care setting, although the trend is not overwhelming. The majority of the studies compare outcomes for the elderly, chronically ill, and mentally ill in Medicaid and Medicare FFS and managed care environments. The detailed findings of these studies be can found in the task force's report on Quality, Cost, and Access.

However, some advocates point out that there are not enough representatives of vulnerable populations in managed care currently to make a valid assessment. They feel that managed care was a system built around employable individuals to handle healthcare for the healthy, and MCOs have traditionally avoided the more needy populations. For example, in the case of chronically ill children in MediCal, their primary healthcare needs are provided

⁵ Interview with Miller, UCSF.

⁶ Interview Tangerine Brigham, see Appendix B.

through managed care, and CCS “carve-outs” and provides a FFS arrangement for service related to their chronic condition. In California today, there is only one MediCal managed care plan for acute HIV AIDS patients. All other plans provide treatment in a managed care arrangement until the t-cell count falls below a certain level, then members are eligible for SSI and rolled into a FFS program because of fear of adverse selection. Also, few HMOs will insure pregnant women as individuals that are not part of a group.⁷ Finally, interviews with clinicians who split their time working at both managed care organizations and county facilities, reveal that although the health plans provide services for the chronically ill and other vulnerable populations, the levels of acuity in the health plans are on average less severe.⁸

Essentially this situation is exacerbated by the perverse incentives built-into the managed care financing model. It does not make sense economically for a health plan to be skilled at treating vulnerable populations, since they are often more costly to treat, and compensation is not commensurate with the additional time and expense. It is possible for a health plan to go bankrupt simply by being able to provide exceptional care for AIDS patients. The risk of adverse selection is therefore a special problem for vulnerable populations, since the incentive may exist for MCOs to profit from subtly inducing sick persons to disenroll through such means as limiting access to needed services (particularly specialty care), poor service, and inconvenience. These incentives need to be adjusted by implementation of risk adjustment per the recommendation in the task force report.

Data also suggests that HMOs by their very nature may have less appeal than FFS for persons with chronic diseases. Several studies have been conducted using Medicare data and have concluded that MCOs tend to attract very good risk.⁹ MCOs historically have had limited cost sharing, but also have had limited access to specialists and hospitals, which does not appeal to those with high expected spending. Below are some of the common features in many MCOs that make them less desirable for the vulnerable and may adversely affect their care:

Under-Treating Patients with Chronic Illness

The inevitable tension that occurs between the drive for cost containment primarily addressed by curtailment of services and the above average need for services by vulnerable populations is significant. Paying physicians by a poorly structured capitation arrangement could encourage providers to overly restrict the amount of care they provide. Since members with chronic illness are most likely to need the greatest amount of care, these are the patients that will be most affected by limits on services.

Restrictions in Seeking Specialists

⁷ Can HMOs help solve the healthcare Crisis, Consumers Union of US, Inc.

⁸ Interview with Helen Miramontes and Sandra Welner, see Appendix B.

⁹ Patients at Risk: Health Reform and Risk Adjustment, Health Affairs, Spring (I) 1994

The current practice by many MCOs of controlling costs by requiring prior authorization of every service not delivered by a primary care physician is not practical for enrollees who rely on specialists, nor is it necessarily cost effective. Certain studies also show that use of a specialist as the primary care giver for a patient with a chronic condition can be more cost-effective in many cases¹⁰.

More importantly, however, is that restricted access to specialists may impact the quality of care in certain cases. A recent study on children with complex pediatric conditions, found that some managed care plans impose restriction on referrals to pediatric specialists and sub specialists which have been found to compromise patient care. The study also found that an increasing number of primary care physicians or adult specialists are attempting to treat severe conditions in which they have little experience. The task force's report on Quality, Cost, and Access cites additional evidence that primary care physicians may lack expertise in diagnosing or treating some chronic conditions, particularly psychiatric conditions. Even for those conditions where a primary care physician is thought to be equally as effective in diagnosing and treating the illness, skills among providers vary widely in any health plan, and there will be varying level of ability to deal with complex needs. Unless quality assurance of highest degree prevails, primary care physicians will be extremely varied in their profiles, and easy access to the necessary expertise is essential.

Lack of Expanded Systems of Care and Definition of Benefits

Public health entities provide certain essential services to vulnerable populations for which privately owned managed care systems are not currently financed, or equipped. Gaps exist in the variability of service packages and in the capability of providers to link with other services necessary for acceptable levels of care. It is essential that plans be able to refer aggressively vulnerable populations to the necessary resources in their communities. Necessary services may include access to housing or disability benefits, advocacy and consumer organizations, childcare, and transportation. Likewise, persons with restricted mobility, impaired mental processes, or sensory deficits will require ancillary services not readily available in primary health care settings.

Overly Narrow Focus on Prevention

Related to the concern that managed care is a system that developed around mainly healthy, employable individuals, is the concern that managed care has been overly focused on prevention at the expense of disease treatment. Additionally, the quality indicators that are currently in place and used by MCOs, for example the HEIDIS CQI indicators, also focus more on prevention than on treatment. For example, current indicators do not include measures of functional status.

Discontinuity of treatment

¹⁰ Ibid.

¹¹ Troubling Signs: Severely Ill Children in Employment Based Managed Care Plans in California,

Persons who require care for chronic or difficult to treat conditions require continuity of care and do best with predictable, competent providers with whom they have developed trusting relationships. In addition, transferring the large body of knowledge to a new physician is not only extremely costly, but may result in “gaps” in medical history and care. The disruption of the relationships with existing providers occurs when an enrollee joins an MCO that does not include the physician as part of their network or removes the physician from their panel. Fear of this disruption can discourage chronically ill from switching health plans (see task force’s report on Quality, Cost, and Access), even when it might be advantageous for them to do so. In addition, the unsteady state of coverage for individuals caused by MediCal eligibility criteria and the on-again/off-again nature of many governmental programs further serves to exacerbate the problem.

Lengthy Time frames for Authorization and Activation of Benefits

The chronically ill and other vulnerable populations have non-traditional benefit needs that are not conducive to normal authorization time frames. For example, getting timely feeding supplies or wheelchair repairs are essential to the day-to-day functioning of these individuals, and must be authorized without delay. In addition, lack of timely medical treatment, durable medical equipment, or physical therapy has been proven to accelerate functional deterioration unnecessarily in certain cases. In some instances in which the situation has been protracted, the dramatic functional loss has resulted in the need for part or full-timed attendant care at home or in RCFEs, long-term care coverage often not covered by MCOs. In addition, lags between the start of employment and activation of health benefits are of considerable importance to individuals with serious illness, since they cannot afford to wait to receive medical services in the interim.

Lack of Consumer Understanding

Vulnerable consumers may be more disadvantaged in their understanding of plan and quality information due to experience, language, culture, and other significant barriers leading to less informed choice. Many quality indicators used by managed care organizations require sophisticated understanding of managed care and the MediCal, Medicare, or other governmental agency processes. It has been demonstrated that there is wide-spread misinterpretation of HEIDIS data, and this finding is more pronounced for the vulnerable¹³. Consumer information is often not presented in user-friendly formats.

Recommendation One

Methods to Identify and Track Vulnerable Populations in Managed Care

According to Mary Dewane, CEO of CalOPTIMA, the most important method for improving care to vulnerable populations is through knowing who your vulnerable members are and tracking them in the system. There are not enough examples of MCOs

¹² Services Center for Independent Living, Pat Strong.

¹³ Consumer Acceptance and Understanding of Quality Data. Health Services Research, 1994.

that have systematic processes in place for flagging those enrollees who are likely to require above average quantities and, or, mixes of services essential to maintaining or improving their health status. Unfortunately, however, there are examples of health plans that have used systematic process and procedures (e.g., red-lining) to flag groups or populations that may require additional services, and subsequently denied them coverage.

There are two main barriers preventing health plans from identifying and tracking their members appropriately. The first barrier is risk of adverse selection. The second barrier to the process is limitations in the data provided and existing information systems. For example, every day CalOPTIMA (CO) receives systems down-loads of data from MediCal related to patients that have gained and lost eligibility; CO estimates an average of 2% of enrollees change status every month. The only information CO receives from the state is the name and social security number; they don't know whether the individual is in a hospital, has diabetes, or if they are pregnant. In fact, they don't even receive a phone number in order to contact the enrollee. In certain cases, the data is not collected and doesn't exist. In other cases, the state has much of this information, since it is the incidence of pregnancy or disability that triggers the eligibility. However, this data is not provided to the plans, partially due to limitations in the information technology.

The first step for improving the care of vulnerable populations in managed care systems is for the State to contract only with those health plans that are able to identify, track, and report performance outcomes for their vulnerable populations effectively. The State of California will drive the quality of care standards and processes for the managed care industry because of both governmental payor and public employee beneficiary leverage. The task force also strongly encourages other purchasers to require appropriate identification and tracking of vulnerable populations in their contracts as well. Currently, many plans rely on independent physicians to identify and meet the special needs of their patients. There is limited effort on the part of the plans as a whole to identify these populations systematically and strategize around them to develop "best practice" treatment practices that can be shared and applied more broadly. Appropriate identification targets those populations where proactive case management will reduce the vulnerability or help maintain functional status, and allows the state to hold plans accountable for meeting enrollees' special needs. It goes beyond eligibility, for example, to categorizing by diagnostic disease category and/or social and economic risk factors, such as illiteracy or candidacy for abuse. Identification should occur at the time of enrollment or physical assessment, at which time issues of patient confidentiality should be addressed through informed consent.

Tracking is an on-going process which ensures that the aforementioned challenges are comprehensively addressed in a systematic way. Appropriate tracking includes proactive case management and care coordination, programs linking enrollees to community agencies or programs providing wrap-around services, appropriate provider network and credentialing to ensure sensitivity, skills, and competencies in regards to these populations, and reporting on performance outcomes. In order to implement this recommendation, procedurally plans must perform the following steps:

1. Assess the general demographics of their member population
2. Segment population
3. Identify vulnerable groups
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5. Develop standard protocols and programs and/or identify existing “best practice” protocols and programs in the community
6. Measure and report on standard performance outcomes

Not only should this recommendation control costs by improving long-term quality outcomes, but comparable quality outcome measures are not possible without segmenting the population. There are several pre-requisite requirements that the state must implement in order to enable the recommendation:

1. Implement risk adjustment per the recommendations in the task force’s report on Risk Adjustment.
2. Develop more comprehensive enrollment forms or a similar tool to collect better demographic and health data upfront, provide this information to plans, and hold plans accountable.
3. Require reporting of standard performance measures that are important to vulnerable enrollees, and publish comparative data among plans.

In presenting this recommendation, the task force gave special consideration to the costs of implementation. In fixed-cost programs, every increase in costs translates into a decrease in services. With the exception of risk adjustment and reporting, in and of themselves, the costs should be minimal. Collecting additional information at the time of enrollment, simply means that additional data elements are added to the form. In some cases, the data actually is already being collected, and it is simply a matter of providing this information to the plans. Credentialing is currently done; what is proposed is expanding the process to include issues of physician competence and skills in regards to particular populations. For example, knowledge of the particular wrap-around services available to certain groups through community organizations. Defining standardized performance measures and collecting data is expensive in terms of the investment in time to reach consensus around measures, and the supporting technology that will be required. However, this is an imperative for the industry as a whole, not only vulnerable populations. Without comparative data consumers will be unable to make informed choices about their healthcare plans.

Cal Optima Model

CalOPTIMA has implemented systematic procedures to identify and track their vulnerable populations. CO uses the Aid Code to identify whether an enrollee is SSI, meaning they are blind and/or disabled; AFDC, meaning the member might be pregnant, or if the member is a foster child. Based on the Aid Code, a customized health services questionnaire is sent to each enrollee in order to learn about their special health needs. As

Ms. Dewane explains a customized survey is required because they are looking for different types of information for the different groups. A health services professional follows-up with enrollees who don't respond.

However, identifying the members health is only the first step, knowledge of their social needs is also critical, and then tracking movement of members among health plans and providers must occur on an on-going basis. For example, thorough tracking is necessary to keep COs' mentally ill patients out of crisis. Extra coordination with pharmacy is necessary, and arrangements to notify CO if the patient turns-up in the ER unexpectedly. Key to successful tracking is "heavy duty" case management and member services coordination. Case managers are assigned to manage the health needs of enrollees, and member services coordinators (MSCs) serve as liaisons between enrollees and their communities, and work to help the enrollee navigate through the system and get things "un-stuck". For example, MSCs will speed-up the authorization time frames for non-traditional benefits and DME, link enrollees with social resources, arrange transportation, and provide pre-natal support out in the communities. In addition, they keep management informed about what's happening out there in the real world with their members, since they have a great deal of one-on-one contact with populations. CO has many specialized tools and programs that assist in successful tracking; such as, good information and decision support technology systems, a traveling medical record (passport to wellness document), and joint programs with community organizations.

MODEL FOR SERVING THE VULNERABLE IN MANAGED CARE

Guiding Principles and Recommendations for Serving Vulnerable Populations in Managed Care

A model for effectively providing care to vulnerable populations is presented in this section. Guiding principles and recommendations that serve as the foundation for the model are summarized in the matrix below, and address many of findings identified earlier in the report. This matrix was prepared in collaboration with many foundations, advocates, and individuals representing vulnerable populations. The task force formally acknowledges their participation in Appendix B of this report.

<u>ACCESS</u>	<u>QUALITY</u>	<u>BENEFITS</u>	<u>PROTECTION</u>
<p>1) Purchasers encourage plans to allow specialist PCPs for members with specific illnesses (Recommendation Physician-Patient Relationship)</p> <p>2) Plans pay for appropriate care from qualified out-of-network provider if plan doesn't include specialty provider qualified to treat enrollee's condition</p> <p>3) Plans to demonstrate integration of acute and long-term care services, as well as linkages to social services in community</p> <p>4) State require and monitor plans compliance with federal and state nondiscrimination and accessibility standards as a condition for retaining their license to operate</p>	<p>1) Plans identify and track medical and social-behavioral needs of vulnerable populations (Recommendation in Vulnerable Populations Report)</p> <p>2) Plans provide services consistent with recognized clinical guidelines and community standards germane to specific medical quality and access</p> <p>3) Plans to credential/certify medical groups and providers based on their knowledge, sensitivity, skills and cultural competence to serve vulnerable populations</p> <p>4) Purchasers adjust payments for quality</p> <p>5) Plans to work with vulnerable populations to adopt or build upon existing quality methodologies (e.g., QARI guidelines) and indicators (e.g., quality of life and functional status, cultural and linguistic aspects of care, and basic health behavior education) for vulnerable populations (Recommendation Physician-Patient Relationship Report)</p>	<p>1) Purchasers to implement risk adjustment (Recommendation in Risk Adjustment Report)</p> <p>2) The Governor and the legislature to direct the State's health plan agencies to ensure that at least 3 of the 5 standard reference coverage contracts meet the expanded benefit and accelerated authorization needs of the chronically ill, and are developed with the active participation of these groups and their advocates (Recommendation in Standardization Report)</p> <p>3) Plans that choose to contract with provider networks through shared risk contracts validate that the capitation rates are appropriate to the expected level of medical risk</p> <p>4) Legislature appoint a Blue Ribbon Panel to achieve consensus on the definition of medically necessary and appropriate and incorporate the concept of maximizing functional capability, which includes maintaining function and preventing or delaying deterioration or loss of function (Recommendation in Who Practices Medicine Report)</p> <p>5) The regulatory authority to require plans and medical group/IPAs to write contractual arrangements that enable chronically ill, acutely ill, or pregnant women to continue seeing their doctors for an extended period of time, unless removed for poor quality (Recommendation Physician-Patient Relationship Report)</p>	<p>1) Plans communicate clearly to enrollees the type of HMO, coverage formularies, customer satisfaction and customized quality measures (Recommendation in Physician-Patient Relationship Report)</p> <p>2) Plans not only to provide written evidence of coverage and membership handbooks, but assure enrollees' understanding of coverage member rights, and benefits</p> <p>3) Plans to allow advocates to assist vulnerable in navigating the administrative or clinical grievance processes of the plan or develop ombudsperson programs to assist the members' rights are protected</p> <p>4) Plans to establish advisory boards with representation from health care professionals, advocacy groups, and consumer representatives for vulnerable groups</p> <p>5) Plans incorporate multimedia education and other innovative techniques to ensure user friendly member education</p> <p>6) State prohibit discharge of enrollee or placement of enrollee in any institutional setting w/o informed consent</p>

Model Components

The task force used the guiding principles and recommendations stated above to establish a model for serving vulnerable populations in managed care settings. In developing this model, the task force also looked at examples of innovative and successful programs already in place in order to establish “best practices” in each of the following areas:

- Consumer Education
- Access to Care
- Quality and Clinical Outcomes
- Consumer Involvement

Models for Consumer Education

One of the often heard complaints from health plan members is their lack of knowledge and understanding about their benefits and how to access them. Consumer education specifically for vulnerable populations must begin at the time of enrollment. All Knox-Keene licensed health plans are required to provide a member handbook and Evidence Of Coverage. These documents are often intimidating to the member and seldom fully read or understood. Some plans provide orientation programs for members, but these programs are seldom well attended. For many beneficiaries who have special needs understanding how to access care and utilize health plan benefits is the first step in assuring access.

In today’s multimedia capable society, it is important that health plans are incentivized to use many of the multimedia educational tools available to support user friendly member education. Tools that have not yet been fully utilized are simple audio cassettes. Most health plan members have access to cassette tape recorders. Another tool currently in use is an automated telephone information management and distribution system that allows members to access information about their benefits and coverage 24 hours a day without the need for an operator. Additional communication technology available to health plans is cable TV and the internet. With the rapid growth of fiber optic cable capability, beneficiaries could call up information on their televisions to obtain beneficiary information as well as health education. Access to the internet is also becoming more prevalent. Member specific internet education programs could be provided to assist the members in their own languages to navigate the health plan system.

Health plans must be encouraged to utilize more effective methods in member education to assure health plan beneficiaries know how to access their benefits. One model that can be emulated is from the school system. In-home educational programs over cable TV or through the internet have become commonplace. Many school systems would actually welcome participating with health plans to help members understand their benefits. As an added dimension, in-home education can be interactive through a personal computer or via a cable television keyboard. For those members who do not have access to cable or a PC, libraries, schools, and doctors’ offices can be places where members should be able to access their plans to receive beneficiary education.

It is time to establish standards for beneficiary education. Plans should be required to demonstrate that their beneficiaries are knowledgeable about their benefits. For vulnerable and special needs beneficiaries this is particularly important. This could be accomplished by requiring that plans perform standardized surveys of these special needs members one month after providing beneficiary information, or to verify understanding by signed affidavit that the beneficiary has received and understands the coverage, member rights, and benefits.

Adequate Access to Care

Many states have set access standards for Medicaid and/or Medicare travel distance and/or time and appointment availability for beneficiaries of health plans. For example, the access standards in the State's contract for Medi-Cal managed care health plans are as follows:

- A. Travel distance must be no more than ten miles for primary care or 30 minutes travel time.
- B. Routine appointments must be available within four weeks of request.
- C. Specialty appointments within two weeks.
- D. Urgent care available within 24 hours.
- E. Emergency care, immediately.
- F. Waiting time in the doctor's office or clinic for an appointed patient must be no more than 30 minutes.

Contracting Medi-Cal health plans are required to monitor and report access and capacity information. These access standards were set in Medi-Cal for participating health plans to assure members would be able, as appropriate, to access primary and specialty care services. Establishing access standards and monitoring such standards forces health plans and health systems to monitor capacity to assure that there are an adequate number of providers in their networks.

For vulnerable and special needs beneficiaries, other "access standards" germane to the need of the members should be established. These standards include facility access standards to accommodate the disabled, cultural and linguistic standards, access to specialty care standards, and access to care services (i.e., transportation, case management, and translation services).

How to Assure Quality and Clinical Outcomes for Vulnerable Populations

One of the significant challenges for government, managed care organizations, and health care providers is to assure the successful application of managed care principles and incentives to beneficiary populations that are uniquely vulnerable to experiencing negative quality outcomes if care is not appropriately managed and provided. Because the payor of coverage for the largest segment of vulnerable persons (i.e., the elderly, blind, disabled, HIV/AIDS, and special needs children) is government, the State of California should rightly have a keen interest in how well managed care, as provided under various models

licensed by the Department of Corporations, assures quality for these special and high need populations.

Why are specialized quality indicators and monitoring processes for vulnerable populations necessary?

Because of the very characteristics of their special needs, vulnerable populations present a unique challenge to any system of care that is based on the principle of managed access to health care services. Because government is the predominant financier of care for most categories of vulnerable populations, contractual definitions of eligibility and scope of benefits financed by government also play a significant role in how systems of care organize around these special need populations. Indeed, it is the fact that the State of California has begun to mandate many of these populations into full risk prepaid capitated contracts that has created an outpouring of quality concern for these high risk populations, even though under government sponsored fee-for-service reimbursement these same quality issues were prevalent. Admittedly, the concerns expressed about managed care stem from very public failures of managed care health plans to assure reasonable access to specialists and/or specialized services or therapies. These perceptions are reinforced by the lack of counter evidence that demonstrates the quality of care and level of access afforded MCO beneficiaries.

The root cause of some of the perceived quality of care failures by managed care organizations can be contributed to the limitations on benefits covered, rather than on the actual quality of care provided. Still, there are a number of quality indicators that should be monitored and reported to assure quality of care for vulnerable members in health plans. These indicators should be specific to the vulnerable or special need category into which the health plan member falls and developed in consultation with them.

There are four major categories for which specific quality indicators need to be developed and standardized:

- | | |
|----------------|--|
| CATEGORY I. | Short term major medical conditions. |
| CATEGORY II. | Chronic medical conditions |
| CATEGORYI III. | Long term medical conditions and/or disabilities |
| CATEGORY IV. | Social/economic conditions |

Category I: Major medical conditions typically involves a catastrophic and traumatic medical event where the prognosis for recovery is generally good. For this type of event, quality indicators should be developed that are based on clinical pathways. A clinical pathway is a well documented and researched medical protocol or process guideline that has been demonstrated to achieve the best outcomes. It was noted in a recent article in JAMA that the cardiac care rendered to minority men versus white males in managed care health plans was significantly different in the use of both advanced technology and rehabilitation therapies. Such major medical events need to be monitored and reported by the MCO. Variance to standard practices should be investigated and clinical outcomes

noted. Health plans need to have established benchmarks and practice guidelines against which to measure the actual clinical processes and outcomes of the providers. Practice advisory boards are often used by many managed care organizations, and this type of proactive quality effort should be encouraged.

Category II: Chronic medical conditions for adults or children need to be monitored and data aggregated by health plans. These conditions need to be tracked by severity and prevalence in the health plan population. Conditions such as asthma, HIV/AIDS, diabetes, and other chronic conditions need to have specialized quality indicators and clinical benchmarks. These conditions are best monitored longitudinally to ascertain not only reduction in episodic severity, but an enhancement of self maintenance and quality of life.

Category III: Long term medical conditions and disabilities are actually the least complicated category of vulnerable populations to manage. Care requirements are generally predictable and constant. Often, family and other care givers participate in the management of care. The frail elderly, the blind, disabled children and disabled adults have a number of “wrap around” services available to them in social service agencies, schools, and other state and local programs. Although health care needs are predictable, access is often a problem. Care to this category of vulnerable population is extremely sensitive to any negative financial incentives for the providers. Quality monitoring must include access standards and quality of life and independence indicators over time.

Category IV: Social/economic conditions of the individuals in managed care health plans would, on the face of it, seem not to be a concern of the health care system. Again, this category of vulnerable populations is predominated by government payors. As Medi-Cal has moved to mandate a wholesale shift from fee-for-service regular Medi-Cal to Medi-Cal managed care, the effect of social, cultural, and economic status has a major impact on how care is provided and the assurance of quality to a uniquely mobile and educationally disadvantaged population. Quality monitors for this population must include cultural and linguistic aspects of care, basic health behavior education, therapy compliance, and public population health indicators.

In 1994, HCFA established guidelines through the Quality Assurance Reform Initiative (QARI) for use by state Medicaid agencies in specifying the components of a health plan’s internal quality management program. Since that time, California has not adopted these guidelines, in whole or in part, or used them as a basis for setting their contractual requirements with health plans. The QARI guidelines were largely based on existing private accrediting standards with exceptions made in areas where it was felt special protections and safeguards were required for Medicaid beneficiaries. The QARI guidelines encompass a broad range of standards relating to the composition of a plan’s internal committee for carrying out quality management and improvement activities, credentialing and re-credentialing processes for providers accepted into a plan’s network, member rights and responsibilities, topics and elements for conducting focused studies on patterns of care and quality indicators.

The State of California, in its contractual requirements under Medi-Cal managed care, has increased the scope and type of quality assurance and monitoring the plan must perform. The State can and should evolve these quality performance processes and guidelines along the same lines as the Quality Assurance Reform Initiative guidelines and processes.

HCFA has contracted with the National Academy for State Health Policy to revise the QARI guidelines and, to the extent feasible within current regulatory authority, develop a common set of quality management standards for Medicaid and Medicare. This initiative, known as the Quality Improvement System for Managed Care or QISMC, will result in the development of a common approach to quality management and improvement, standards, and reviewer guidelines to evaluate compliance with the standards. Public review documents will be available in the Fall of 1997 with final approval expected in June, 1998.

Quality Oversight and Quality Reporting

Monitoring and reporting relevant quality indicators so that consumers can make informed choices has been a common complaint of both consumer advocates and payor/purchasers of health plan coverage. On this issue everyone seems to be in agreement that quality of care oversight is a key responsibility of health plans and their provider networks. Even though there is agreement on the need for quality oversight and reporting, there remains significant disagreement on the relevance and significance of specific quality indicators. There are some standard indicators that are generally used and reported by health plans to validate quality:

- Emergency room usage and care
- Incidence of preventable disease
- Children's health screenings
- Immunization rates
- Member satisfaction
- Rates of cancer screening and early diagnosis

Current quality indicators tend to focus on process rather than outcome. This is mainly because of the lack of longitudinal data and the information system limitations in most plans.

Medical groups and health systems have taken up some of the slack, but often the data is limited and cannot be applied to the managed care membership as a whole. Quality indicators and oversight monitoring for vulnerable and special need health plan members is much less organized and rarely, if ever, reported for consumer evaluation. In fact, health plans are adverse to sharing their performance information when it involves populations that might adversely select them if they are performing well and publicly criticize them if they are not performing well. When these populations are sponsored by state or federal programs such as the managed care program for disabled children (CCS) or frail elderly

(PACE), government agencies do require extensive quality reports on a wide variety of both process indicators and quality outcomes.

Consumer Involvement in Decisions Regarding their Personal Health Care Benefit Design and Administrative Process Improvement

The relationship between the consumer and the managed care organization of which they are a member is a unique one. If you look purely at the relationship that the consumer member has with their MCO, you can understand why consumers have become so frustrated. The managed care organization is primarily an intermediary that insures care is provided and evaluates and controls the need for access to the services provided. In essence, the consumer's surrogate is the managed care organization that contracts with the provider or health system and authorizes or enables access. The member is not truly an independent consumer who can make a choice at the time of need based on the best value, but rather is dependent on the choice of others. Compounding this disenfranchisement of the consumer member from the decision process is the often admitted lack of knowledge or understanding of the choices available.

There are three main choice categories that consumers must have the right to participate in and that payors of health plans must be proactive in ensuring informed choice and/or decision making:

- First: Choice of health plan and health plan provider network.
- Second: Choice of health care access point.
- Third: Choice of medical care or treatment options based on benefit design.

Payor, in conjunction with its health plan contractor, must evaluate the level of personal involvement health plan members are afforded. Satisfaction surveys are usually inadequate for this purpose. Because most beneficiaries usually make their choice at a time when they are not sick or in crisis, it is difficult to predict what services will be required while a member of the health plan. In most cases the payor provides comparison information that gives the prospective health plan beneficiary some idea of differences between plan options. The problem with the comparison sheets is that they do not include performance data.

For example, if you compare the way the automotive industry has provided comparative data to potential customers, you can easily get comparative data on a car's gas mileage, engine performance, wheel turning ratio, 0-60 mph performance, interior cubic feet, etc. The comparative data for the health plans would be the equivalent if the car dealer supplied only the most basic data, such as:

Engine	Yes
Four tires	Yes
Uses gas	Yes
Comes in the following sizes	Large, Medium, Small

This illustrates how difficult it would be to make an informed choice with such basic information go on. One example where the health care industry has been successful, at the encouragement of government established standards for informed consent, is in the area of living wills. Patients and families are not only offered, but encouraged, to fully participate in this very sensitive personal decision. The process requires that a trained counselor assist the person with their living will describing all the options and considerations and verifying understanding and acceptance by the patient.

A similar system of informed choice is needed for those populations that could be categorized as vulnerable. Health plans need to make special efforts to ensure understanding and acceptance of the member regarding benefits, limitations, and processes to access care; participate in health care decisions; and appeal or grieve decisions made by the provider or health plan. Health plans should allow member advocates to assist vulnerable members navigate the administrative or clinical grievance processes of the plan. Health plans should be encouraged to work with advocacy groups or develop ombudsperson programs that will serve to assure the members' rights are protected. Health plans should be encouraged to provide information and other resources to such advocacy groups that assist the vulnerable populations in managed care. The level of member satisfaction with the information they received and/or were verbally counseled on needs to be monitored and tracked. Standards for informed choice should be established by the payor.

Also, health plans should establish advisory boards with representation from health care professionals, advocacy groups, consumers representing the vulnerable populations within the health plan. The advisory committee role is to provide input into benefit design, administrative processes, access standards, member satisfaction issues, and care coordination processes. Advisory committees should have established work plans, access to performance data, and be publicized to all plan members. There should also be a mechanism for health plan members to correspond with these advisory committees.

UNINSURED AND SAFETY-NET PROVIDERS

What the Data Shows:

When trying to ascertain the impact of managed care on those outside the system what is usually compared is the impact of managed care on the number of uninsured versus the impact on their access to care.

Proponents of managed care believe that this system of financing results in a lower number of uninsured. According to the Lewin Group in their nation-wide study¹⁴ it was estimated that managed care saved purchasers of private insurance between \$23.8 billion and \$37.4 billion in 1996. Managed care, therefore, makes it possible for people to retain their insurance coverage by making insurance premiums more affordable. The study indicates that if it were not for managed care, the growth in health care costs would have been much higher, causing many employers and individuals to discontinue their coverage. Lewin estimates that this would have increased the number of uninsured by an additional 3.1 to 5.0 million persons in 1996 alone. Thus, managed care's impact on the affordability of coverage helped reduce the uninsured population below what it would have been in the absence of managed care.

The flip-side, however, is the impact that managed care has on the ability of safety-net providers to support uncompensated care. According to the Rand nation-wide study on uncompensated care¹⁵, when measured in real terms, the level of uncompensated care grew by 150 percent from 1983 to 1995. However, the increase in uncompensated care levels after 1988 appears not to have kept pace with the growth in hospital expenses or the number of uninsured. Although changes in uncompensated care have been modest in the aggregate, there have been significant distributional shifts in hospitals serving a large share of the Medicaid population experiencing increases in uncompensated care relative to hospitals with a lower share of the Medicaid population. In addition, the Rand study indicates suggestive evidence that higher levels of managed care penetration are associated with lower levels of uncompensated care delivery.

So What Does this Mean?

It is hard to net a bottom-line from the above data, since the number of uninsured is clearly a different measurement than access to care for the uninsured. However, the studies do point to some instructive trends. First, the implications of the Rand study are serious for states shifting Medicaid recipients into managed-care settings. The researchers find that HMOs serving Medicaid patients are ratcheting down hospital payment rates and utilization, and that the mainstreaming of Medicaid recipients is reducing the paying patient base of traditional indigent care providers, leaving them without resources to support uncompensated care. Add, to this the fact that when the State implements policies

¹⁴ Managed Care Savings for Employers and Households: Impact on the Uninsured, prepared for the AAHP, June 1997.

¹⁵ A Profile of Uncompensated Care, 1983-1995, Rand Group, Health Affairs.

aimed at controlling costs, such as denying care for pregnant women who are not US citizens, this does not mean that care is actually denied, it simply means the care is restricted, and the burden is shifted to the safety-net. The law makes these women ineligible for MediCal and the pre-natal care programs that go along with it. Instead, county and other safety-net providers, who are becoming increasingly overburdened as their percentage of uninsured increase and their level of MediCal dollars decrease, are picking-up more of the slack. More money is required from the county, shifting dollars away from other public services, many of which are also critical for preserving the health of the community (e.g., sewage disposal).

Trends such as these are jeopardizing our safety-net, which reduces the stand-by protection for the uninsured. While acknowledging the extremely valuable role these organizations play and the importance of including them in solutions developed, it also needs to be pointed out that continuing to subsidize the safety-net in its present form is not a solution to the problem of the uninsured. Currently, safety-net providers do not actually “manage care” for the uninsured; the care delivered is neither preventative nor continuous. Although data has been inconclusive regarding quality of care in FFS vs. managed care environments, there is evidence that populations in government sponsored managed care programs fare better than the uninsured in terms of access to care and health outcomes. In addition, the uninsured typically enter this safety-net system through the most expensive portals, in a more acute state, driving-up costs in the system. Proponents of managed care believe that it would be more cost effective to treat this population as a managed one, with a focus on continuity and prevention, rather than continue to serve it with the fragmented, reactionary services offered through the safety-net currently.

RECOMMENDATION TWO

The task force recommends that going forward the state “ earmark” and allocate a portion of the costs avoided attributable to MediCal selective contracting and CalPERS managed care to begin expanding coverage to California’s uninsured population The State has indicated that it has saved billions of dollars through the MediCal competitive contracting program alone – a total of more than \$5.7 billion since 1983, and approximately \$1.3 billion for the 1996-97 fiscal year. These funds would have been spent had the State continued operating under the traditional, cost-based reimbursement system currently in place in most of the U.S.¹⁶. The tables on the next page show that CalPERS premiums would have been substantially higher if their growth had resembled that of the rest of the nation, resembled that of the ten states with the lowest managed care penetration, or continued to grow at the pace they had experienced during the five years prior to 1992.

¹⁶ CA Med Assistance Commission, Update of the Annual Report to the Legislature, January 1997.

RECOMMENDATION 2
(continued)

PERCENT CHANGE IN PREMIUMS

	1992-93	1993-94	1994-95	1995-96
PERS Premium Change	.061	.014	-.011	-.04
US Premium Change	.059	.038	.056	.013
10 States with Least Penetration of Managed Care Premium Change	.093	.028	.133	.061
Premium Change if Continued Growth Reflective of 5-Year Period Prior to 1992	.15	.15	.15	.15

DOLLAR DIFFERENCE IN ANNUAL PREMIUMS

Annual Premiums	1992	1993	1994	1995	1996
\$ PERS Premium	\$3685.20	\$3909.96	\$3964.80	\$3921.24	\$3764.40
\$ PERS Premium if % Change Like US		\$3903.84	\$4052.88	\$4278.84	\$4335.12
\$ PERS Premium if % Change Like States with Least Penetration of Managed Care		\$4026.24	\$4139.04	\$4691.16	\$4979.28
\$ PERS Premium if Continued Growth Reflective of 5-Year Period Prior to 1992		\$4237.98	\$4873.68	\$5604.73	\$6449.16

Costs avoided for CalPERS in 1996 ranged between \$570 and \$2685 per employee or between \$250 million and 1.2 billion for all prime lives¹⁷. If all public employees in the state were rolled into CalPERS, costs avoided could have ranged from \$1 billion to 4.8 billion in 1996¹⁸. Although there will be start-up costs initially, the goal would be for the program to pay for itself by reducing the costs associated with caring for this population over the long-term. As costs come down, premiums become more affordable, enabling further expansion of coverage for the uninsured, consistent with the findings in the Lewin study cited above.

¹⁷ Calculation assumes 436,704 prime lives as of April 1997.

¹⁸ Based on 1,796,400 total state and local government employees as of September 1996, California Research Bureau statistics.

Preliminary Draft—For Discussion
(Contents and Recommendations Herein Have Not Been Approved by the Task Force)

In implementing this recommendation the task force views the State's role as being one of incentivizing the counties versus establishing a new entitlement program for the state. The task force believes this to be appropriate, since the definition of vulnerable will vary by county, and a state-wide solution will not meet the individual needs of the different counties appropriately. In addition, county financial resources support a great deal of this care, and much has been invested in the development of the existing safety-net. It is important to draw upon these resources and identify how to utilize them in creative, new ways, rather than starting from scratch. Several Boards of Supervisors have already begun this process by developing plans for rolling their Section 17,000 uninsured into managed care, and other counties should be able to build upon the progress that has been made to-date. This recommendation is much more incremental in nature than a state-wide solution, relying on the state to energize and incubate county initiatives, and then disseminate innovate models to be expanded and built upon.

Preliminary Draft—For Discussion
(Contents and Recommendations Herein Have Not Been Approved by the Task Force)

TABLE I: SPECIAL NEEDS OF VULNERABLE POPULATIONS

CATEGORY	TYPE/GROUP	SPECIAL NEEDS
Children/Infants	Premature infants and high risk babies	1. NICU 2. Case management 3. Specialize OP care
	Foster children	1. Annual physical exam 2. Case management 3. Abuse prevention
	Disabled children	1. Special medical equipment 2. Special transportation 3. Case management 4. Access to specialist 5. Specialized diagnostic screening/therapy
	Abused children	1. Mental health services 2. Annual physical exam 3. Short term case management
	Chronically ill children	1. Access to specialized disease management 2. Short term case management 3. Health education
	Language disadvantaged minorities	1. Culturally and linguistically competent medical 2. Health education
Elderly	Elderly frail/chronically ill	1. Home and community based care 2. Institutional care 3. Case management 4. Medical equipment 5. PT/RT services 6. Infusion services 7. Housekeeping services
	Elder disabled	1. DME 2. Home/community based care 3. Case management 4. PT/RT
Medically vulnerable	HIV/AIDS and other high risk medical conditions	1. Specialized drug therapies 2. Case management 3. Hospice 4. Mental health 5. Specialized medical care
	Short term major medical conditions	1. Special therapies and procedures 2. Case management 3. Special health education

TABLE II: TYPES OF VULNERABLE POPULATIONS

CATEGORY OF VULNERABLE POPULATIONS	TYPE/GROUPS	GOVERNMENT PROGRAMS
Children/Infants	Premature infants Foster children Disabled children Abused children Chronically ill Disadvantaged Minority Children	CCS Medi-Cal/Special County Funds CCS None/Emergency Medi-Cal CCS Primarily School Based or Private Insurance
Teenagers/Adolescents	Disabled Pregnancy-Sexuality	CCS Medi-Cal
Adults	Poor Chronically ill/HIV/AIDS Mentally ill Unemployed (not poor) Special needs/adults Women of childbearing age Minorities/Women	Medi-Cal SSI/Medi-Cal Limited Medi-Cal/SSI Limited Medi-Cal SSI/Medi-Cal Limited Medi-Cal No special programs
Elderly (65+)	Chronically ill Terminally ill Elderly disabled	Medicare/Medi-Cal Medicare Medicare

APPENDIX A – COMPARISON OF QUALITY AND ACCESS IN FFS AND MANAGED CARE FOR VULNERABLE POPULATIONS

The results of Miller and Luft's recent study¹⁹ on managed care versus FFS performance indicates that HMOs produce better, the same, and worse quality of care depending on the particular organization and particular disease. In regards to the chronically ill or diseases that require the most care there were indications that these populations and illnesses fare slightly worse in managed care, although the trend was not overwhelming. However, three of the five observations with significant negative HMO results focus on chronically ill, low-income enrollees in worse health, impaired or frail social health maintenance organization (SHMO) demonstration enrollees, and Medicare home health patients, many of whom have chronic conditions and diseases. While it is true that some quality of care results that show better or mixed HMO quality are also at least partially based on data for patients with chronic conditions and diseases, and that there are many valid cautions against over-interpreting the results, the fact that three significantly negative HMO quality of care results for Medicare HMO enrollees with chronic conditions and disease warrants attention. The task force's report on Quality, Cost, and Access provides detailed descriptions of several studies summarized by Miller and Luft, as well as additional research studies on quality of care for vulnerable populations.

¹⁹ Does Managed Care Lead to Better Or Worse Quality of Care?, *Health Affairs*, September/October 1997.

APPENDIX B -- ACKNOWLEDGEMENT OF CONTRIBUTION

The Task Force would formally like to acknowledge and thank the following individuals and organizations in their valuable and tireless efforts:

- Tangerine Brigham – Director of Policy and Planning San Francisco Department of Public Health
- Carolyn Castillo, Administrative Assistant for Medical Care Services, Department of Health Services
- Harry Christie
- Mary Dewane, CEO, CalOPTIMA
- Elizabeth Jameson, J.D., and Lori Evans, M.P.H., Institute for Health Policy Studies, UCSF School of Medicine
- Helen Miramontes, Associate Clinical Professor, School of Nursing, University of California, San Francisco
- J.D. Northway, M.D., Valley Children’s Hospital and Task Force Member
- MaryAnn O’Sullivan, Health Access Foundation and Task Force Member
- Laura Remson Mitchell, Government Issues Coordinator, Multiple Sclerosis California Action Network
- Pat Strong, Services Center for Independent Living
- Elizabeth Wehr, J.D., Center for Health Policy Research, The George Washington University Medical Center
- Sandra Welner, M.D., Primary Care Gynecologist for Women with Disabilities and Chronic Medical Conditions, Private Practice
- Roberta Whn, UCLA Center for Health Policy Research